Additional Health Information & Epi-Pen Form

Health Insurance Provider: _____ Plan or Group # _____

Participant's Physician: _____ Phone: _____

Does the participant wear prescription eye glasses or contacts? Yes _____ No _____

Medical Conditions

Does the participant suffer from Asthma? Yes _____ No _____

If yes, is the Participant's asthma exercise induced? Yes _____ No _____

Does the participant carry a rescue inhaler? Yes _____ No _____

Has the participant been diagnosed with Hypertension? Yes _____ No _____

Has the participant been diagnosed with Diabetes? Yes _____ No _____

Has the participant been diagnosed with Epilepsy/Seizures? Yes _____ No _____

Has the participant been diagnosed with Heart Disease? Yes _____ No _____

Has the participant been diagnosed with any other medical condition(s) not listed above? Yes _____ No _____

Please list any medication the participant is currently taking and why: _____

(Attach Additional Sheet if Necessary)

Allergies

Does the participant have any life threatening allergies? (food, medication, plants, animals, insects, etc) Yes _____ No _____

Participant's anaphylaxis triggers are:

_____ Peanuts _____ Nuts _____ All Dairy _____ Eggs _____ Shellfish _____ Fish

_____ Food Additives, please list: _____

_____ Insects/Bites, please list: _____

_____ Medications, please list: _____

_____ Others, please list: _____

Participant's anaphylaxis symptoms usually are:

____ Swelling (eyes, lips, face, tongue) ____ Coughing/Choking ____ Difficulty Breathing/Swallowing ____ Vomiting

____ Stomach Cramps/Diarrhea ____ Flushed Face/Body ____ Dizziness/Confusion ____ Cold, Clammy, Sweaty Skin

____ Fainting/ Loss of Consciousness ____ Change of Voice ____ Other, please list: _____

Participant's emergency treatment is:

____ Anti-Histamine (with Precise measuring instrument, please list specific brand and dosage): _____

____ Epi-Pen; Expiration date: ____ / _____ / _____

EPI-PEN REQUIREMENTS: (Participant's Parent or Legal Guardian please initial after each of the below listed requirements)

- Participant's parent or legal guardian must provide the program with 2 current, non-expired Epi-Pens *(initials)* _____
- Epi-Pen must be in original container with appropriate label intact *(initials)* _____
- Participant must be trained to administer the Epi-Pen without assistance *(initials)* _____

Number of times the participant has used and Epi-Pen: _____ Date of last use: _____ / _____ / _____

In the Event of an Anaphylactic Reaction:

1. Staff/Program Instructors may provide assistance to the Participant as he/she injects him/herself. Please Note: Staff/Program Instructors are not trained medical professionals, but have completed the Standard First Aid Training and will assist to the best of their ability.
2. Staff/Program Instructors will call 9-1-1 immediately to have an ambulance come to the program/event site.
3. Staff/Program Instructors will call parent/legal guardian/emergency contact to inform them of the incident and to inform them the Participant is being transported by emergency personnel to the hospital.

Epi-Pen Waiver (Only if participant requires and Epi-Pen on-site)

I release Lake Havasu City, and its officers, directors, employees, independent contractors, and volunteers from any and all liability arising out of or in connection with the decision to administer or not administer or to assist with the administration of epinephrine.

I agree to indemnify and hold harmless Lake Havasu City, and its officers, directors, employees, independent contractors, and volunteers of and against any and all liability, damage, claim, demand, cost, and expense (including without limitation of attorney's fees) arising out of or in connection with the use or non-use of an Epi-Pen for Participant and any action, claim, or other legal proceeding brought against Lake Havasu City by a parent/legal guardian/spouse/family member who has not signed in agreement.

Parent/Legal Guardian Signature: _____